

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 4 3 3

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) James NMN Bentley			2a. DATE OF DEATH MONTH DAY YEAR February 25, 1985		2b. HOUR 4:29 ^A M
3 SEX Male	4 RACE Black	5. DATE OF BIRTH MONTH DAY YEAR Feb. 28, 1907		6 AGE (IN YEARS LAST BIRTHDAY) 77 yrs.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kent Co. Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.	
10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent and Queen Anne's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer	12b. KIND OF BUSINESS OR INDUSTRY Farm	
13a. STATE Md.	13b. COUNTY Kent	13c. CITY OR TOWN Rock Hall	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE 21661 Lover's Lane RFD	
14. FATHER'S NAME FIRST MIDDLE LAST John Bentley			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alverta Graves		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 220 12 2149		17. INFORMANT 514 Fifth St. S. E. Minnie Atkins Washington, DC. 20003	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Collapse					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min
DUE TO, OR AS A CONSEQUENCE OF (b) Ventricular Fibrillation					5 min
DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Right middle lobe pneumonia; Diabetes					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from above, (I) (we) (did) (did not) view the body after death. 19 85 2/25 8:15 to 2/25 19 85					
22b. SIGNATURE C G Gottfried Baumann		DEGREE MD		22c. DATE SIGNED 2/26/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C Gottfried Baumann		22e. ADDRESS Chestertown, Md. 21620			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 3/2/85	23c. NAME OF CEMETERY OR CREMATORY Sharptown Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Rock Hall, Md.	
24. FUNERAL DIRECTOR NAME James A. Perkins		ADDRESS Rock Hall, Md.		25a. DATE REC'D. BY REGISTRAR MAR 06 1985	



20% COTTON 100% WOOL

WINTER 1950

IN SENATE

JANUARY 1, 1901

REPORT OF THE
COMMISSIONERS OF THE
LAND OFFICE
FOR THE YEAR 1900

ALBINO



LAND OFFICE

San Francisco, California

Printed by the State Printer

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the funeral director.

BP

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 4 3 5

1- FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Caroline Isabell Brown			2a DATE OF DEATH MONTH DAY YEAR February 8, 1985		2b HOUR MIN 11:24 A	
3 SEX FEMALE		4 RACE BLACK		5 DATE OF BIRTH MONTH DAY YEAR JUNE 4, 1910		6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS. MONTHS DAYS
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Kent County MD.
10 CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABOR		12b KIND OF BUSINESS OR INDUSTRY BARBERS
13a STATE MD		13b COUNTY KENT		13c CITY OR TOWN Chestertown		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST William BARROLL		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AURA BUTLER		13e STREET ADDRESS / ZIP CODE R.F. 201620		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-20-2672		17 INFORMANT ADDRESS		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) plasma Cell Dyscrasia DUE TO, OR AS A CONSEQUENCE OF (c) pneumonia						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 1/16/85 , 19 85 , to 2/8/85 , 19 85 , that (I) (we) last saw the deceased alive on 2/8/85 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Kin Kue Wun, M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED, 2/15/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kin Kue Wun, M.D.		22e. ADDRESS Chestertown, Maryland 21620				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2-14-1985		23c. NAME OF CEMETERY OR CREMATORY RICH NECK HALL		23d. LOCATION CITY OR TOWN COUNTY STATE CHESTERTOWN MD
24. FUNERAL DIRECTOR NAME Kenneth W. W.		ADDRESS CHESTERTOWN		25a. DATE REC'D. BY REGISTRAR FEB 19 1985		25b. REGISTRAR'S SIGNATURE Davidson

MEDICAL CERTIFICATION

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 4 3 6

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Marian Elizabeth Coleman			2a. DATE OF DEATH MONTH DAY YEAR February 22, 1985		2b. HOUR 12:32AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 27, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.	
10. CITY OR TOWN OF DEATH Chestertown	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent and Queen Anne,s Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Kent	13c. CITY OR TOWN Rock Hall	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE Box 248 21661	
14. FATHER'S NAME FIRST MIDDLE LAST Bud Ford Potts			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Harding		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-12-1420B		17. INFORMANT ADDRESS MD 21661 Mildred Fithian, Rt. 2 Box 17 Rock Hall	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Colon DUE TO, OR AS A CONSEQUENCE OF Bleeding 2° #1. (b) Ascites DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
MEDICAL CERTIFICATION					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE [Signature] DEGREE				22c. DATE SIGNED 2/28/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 02/24/85		23c. NAME OF CEMETERY OR CREMATORY Crompton Cemetary	
23d. LOCATION CITY OR TOWN Crompton		COUNTY Q.A.		STATE MD	
24. FUNERAL DIRECTOR NAME Tom Helfenbein Funeral Homes, Church Hill, MD				25a. DATE REC'D. BY REGISTRAR MAR 6 1985	
ADDRESS				25b. REGISTRAR'S SIGNATURE [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

BP _____

DHMH - 16 60M 7/84
(VRA 15, 4)STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5

0 5 4 3 7

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Madeline NMN Cronan				2a. DATE OF DEATH MONTH DAY YEAR February 1 1985				2b. HOUR 11:45^A	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 1-23-06		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD			
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent and queen Anne's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MANAGEMENT RADIO		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY AA		13c. CITY OR TOWN BEVERNA PK		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS & ZIP CODE 853 Cottonwood Dr 21146	
14. FATHER'S NAME FIRST MIDDLE LAST William S ENSIGN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADA BISHOP					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 577030024		17. INFORMANT ADDRESS FRANCES STANFIELD - A ROUE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) - Severe Vasc insufficiency									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)			
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (his hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>[Signature]</i> DEGREE <i>[Signature]</i>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-1-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) (HOSPITAL) CHESTERTOWN, MD						22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 2-4-85		23c. NAME OF CEMETERY OR CREMATORY CATE OF HEAVEN		23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING MONT. MD.		
24. FUNERAL DIRECTOR NAME ADDRESS Paul S. Banano Sewana Pl Md						25a. DATE REC'D. BY REGISTRAR FEB 06 1985			
						25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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W. H. F. H. H.

NOV 11 1903

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 4 3 8

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Cora Iola Dowling			2a. DATE OF DEATH MONTH DAY YEAR February 8, 1985		2b. HOUR MIN 7:32 A		
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Dec. 9, 1912		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. 72	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD	
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent and Queen Anne's Hospital, Inc.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk (Store)		12b. KIND OF BUSINESS OR INDUSTRY 21661	
13a. STATE Maryland		13b. COUNTY Kent		13c. CITY OR TOWN Rock Hall		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles W. Thomas		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Matthews		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220 32 1418	
17. INFORMANT ADDRESS Charles Dowling Rock Hall, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASHD DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs		19. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1975 , to Feb. 8, 1985 , that (I) (we) lost saw the deceased alive on 2/7 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE Calvin Kaufman		DEGREE MD		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/8/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. Calvin Kaufman		22e. ADDRESS Rock Hall, Md. 21661					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/10/1985		23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cemetry		23d. LOCATION CITY OR TOWN COUNTY STATE Rock Hall, Md.	
24. FUNERAL DIRECTOR (NAME) Willis Wells		ADDRESS Chestertown, Md.		25a. DATE REC'D. BY REGISTRAR FEB 15 1985		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	

IMPORTANT: If item 21 is marked "bulletin 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 4 3 9

FOR
1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) John A HERSCH			2a. DATE OF DEATH MONTH DAY YEAR Feb. 26, 1985		2b. HOUR P. M.	
3. SEX Male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR June 27, 1910		6. AGE (IN YEARS LAST BIRTHDAY) 74	7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kent Co. Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.		
10. CITY OR TOWN OF DEATH Rock Hall	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) At Home Rte # 20			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waterman		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md.			13c. COUNTY Kent		13d. CITY OR TOWN Rock Hall	
14. FATHER'S NAME FIRST MIDDLE LAST John Raymond Hersch			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha E. Walbert		13e. STREET ADDRESS / ZIP CODE Rte # 20 21661	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 220 22 0405		17. INFORMANT ADDRESS Rte # 20 Va. Hersch Rock Hall, Md. 21661		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Stomach</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>2/26/85</u> , 19____, to <u>2/26/85</u> , 19____, that (I) (we) lost saw the deceased alive on <u>2/26/85</u> , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>H. Calvin Kaufman</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/27/85
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. Calvin Kaufman				22e. ADDRESS Rock Hall, Md.		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 3/1/85		23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Rock Hall, Md.
24. FUNERAL DIRECTOR NAME <u>J. W. Wells</u>				25a. DATE REC'D. BY REGISTRAR MAR 06 1985		
				25b. REGISTRAR'S SIGNATURE <u>J. W. Wells</u>		

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 85 05440			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR A M			
1. DECEASED NAME FIRST MIDDLE LAST IRMA V. HICKMAN				February 17, 1985 10 M			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Nov. 7, 1918		6. AGE (IN YEARS LAST BIRTHDAY) 66 yrs. YRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kent Co. Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent Co. MD.	
10. CITY OR TOWN OF DEATH Still Pond		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) At Home Maple Ave		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.				13b. COUNTY Kent		13c. CITY OR TOWN Still Pond	
14. FATHER'S NAME FIRST MIDDLE LAST John Hessey Haddaway				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Carroll			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 214 30 8772		17. INFORMANT ADDRESS Maple Ave. Albert Hickman Still Pond 19667			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute idiopathic Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Advanced Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Longstanding Diabetes Mellitus Complicated By Aorta</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>no</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3/19</u> , 19 <u>71</u> , to <u>2/17</u> , 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>2/14</u> , 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>C Gottfried Baumann</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/18/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C Gottfried Baumann				22e. ADDRESS Chestertown, Md. 21620			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE 2/19/85		23c. NAME OF CEMETERY OR CREMATORY Still Pond Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Still Pond, Maryland	
24. FUNERAL DIRECTOR NAME <u>Willis Wells</u> ADDRESS <u>Chestertown, Md.</u>				25a. DATE REC'D BY REGISTRAR <u>FEB 26 1985</u>		25b. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

BP.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORT ANT: If item 21 is marked (a), item 18 should signify injury or other traumatic event, the medical examiner must be notified and advised.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

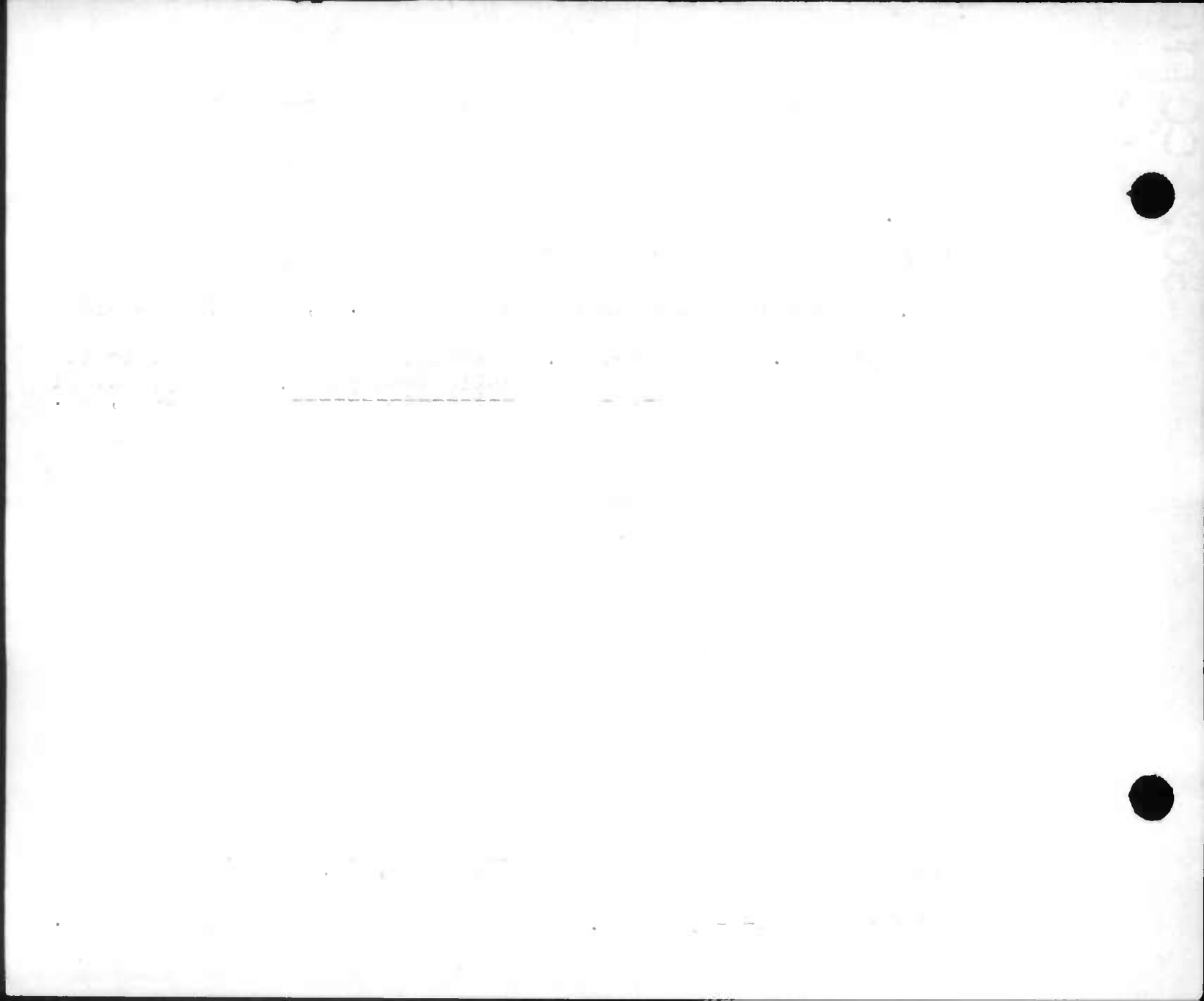
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1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Charles Henry Hines Jr.			2a. DATE OF DEATH MONTH DAY YEAR February 5, 1985			2b. HOUR 1:35 M				
3. SEX Male		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR July 31 1896		6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD.				
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY Farming		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Queen Anne's Pondtown		13c. CITY OR TOWN Pondtown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE RT. 1, Box 477 21651	
14. FATHER'S NAME FIRST MIDDLE LAST Charles H. Hines Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Augusta Elliotte			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				
16b. SOCIAL SECURITY NO. 218-16-7845			17. INFORMANT Julia Johnson RT. 1 Box 477 21651 Elizabeth Hines- Pond town, Md.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (b) severe dehydration, pneumonia DUE TO, OR AS A CONSEQUENCE OF (c) As a result of Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 hrs 3-4 days unknown				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Michel Bey						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michel Bey				22e. ADDRESS Unicorn Medical Center Millington, Md. 21651						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2-9-85		23c. NAME OF CEMETERY OR CREMATORY Mt. Pleasant		23d. LOCATION CITY OR TOWN COUNTY STATE Pondtown WA Md.				
24. FUNERAL DIRECTOR Follows Funeral Home Millington				25a. DATE REC'D. BY REGISTRAR FEB 1 9 1985		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall				

BP _____



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 1. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 85 05442					
1. DECEASED NAME (TYPE OR PRINT) BARBARA J. JACKSON						2a. DATE KNOWN OF DEATH ESTIMATED Feb 21, 85		2b. HOUR 6:00		2c. DATE PRONOUNCED DEAD Feb. 21, 1985		2d. HOUR 6:30			
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 1-22-46		6. AGE (IN YEARS) LAST BIRTHDAY 39 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD Feb. 21, 1985		7d. HOUR 6:30	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Kent			
10. CITY OR TOWN OF DEATH Chestertown				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RFD Woods Edge Apr. # 3D						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer				12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.				13b. COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RFD Fairlee 21620					
14. FATHER'S NAME FIRST MIDDLE LAST Calvin Roe Merchant (Sr.)						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Doris Rider									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 216 48 6098		17. INFORMANT Doris Hyland				ADDRESS Rock Hall, Md. 21661					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hanging DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6:00 P.M. 2-21 1985				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) hung herself							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE RFD 2, Chestertown, Kent, Maryland							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE Robert W. Farr				TITLE (SPECIFY) Deputy				MEDICAL EXAMINER				DATE SIGNED 2/22/85			
EXAMINER'S NAME (TYPE OR PRINT) Kent Co. Chestertown				ADDRESS Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 2/24/85		23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Rock Hall, Md.					
24. FUNERAL DIRECTOR NAME John Wells				ADDRESS Chestertown, Md.				25a. DATE REC'D. BY REGISTRAR FEB 28 1985				25b. REGISTRAR'S SIGNATURE Julia Davidson			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 16. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) JOSEPH H JOHNSON			2a. DATE KNOWN OF DEATH MONTH DAY YEAR 1-31 1985			2b. HOUR 1:00 PM		
3. SEX MALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR JULY 12, 1972	6. AGE (IN YEARS) (LAST BIRTHDAY) 72 YRS.	IF UNDER 1 YR. MONTHS DAYS 0 0	IF UNDER 24 HRS. HOURS MIN. 0 0	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR JAN 31, 1985		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH KENT MD.		
10. CITY OR TOWN OF DEATH CHESTERTOWN		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) AT HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABOR		12b. KIND OF BUSINESS OR INDUSTRY VARIOUS
13a. STATE MD.			13b. COUNTY Kent	13c. CITY OR TOWN CHESTERTOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 202 CANNON ST.		
14. FATHER'S NAME FIRST MIDDLE LAST UNK				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST NORA CARTER				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) 577-16-7134		17. INFORMANT NAME ADDRESS MRS. CLARA BROWN 202 CANNON ST. CHESTERTOWN MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease with DUE TO, OR AS A CONSEQUENCE OF Pulmonary Complications (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE Robert W. Farr			TITLE (SPECIFY) Deputy			DATE SIGNED 2-1-85		
EXAMINER'S NAME (TYPE OR PRINT) ROBERT W. FARR			ADDRESS CHESTERTOWN MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2/8/1985		23c. NAME OF CEMETERY OR CREMATORY MD. Eastern Shore VET. GEN		23d. LOCATION CITY OR TOWN COUNTY STATE BEOLA H Dorchester MD		
24. FUNERAL DIRECTOR NAME Robert W. Farr			ADDRESS CHESTERTOWN MD.			25a. DATE REC'D. BY REGISTRAR FEB 1 5 1985		
						25b. REGISTRAR'S SIGNATURE John Davidson		

Numbered Death
Silence

Item 13e per phone 3/6/85 dad

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 4 4 4

1- FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
FIRST MIDDLE LAST Clara Mae Joiner		MONTH DAY YEAR February 12, 1985	
3 SEX Female		2b. HOUR 11:24P	
4. RACE White m		6. AGE (IN YEARS LAST BIRTHDAY)	
5. DATE OF BIRTH MONTH DAY YEAR Dec. 27, 1900		84 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD.	
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent and Queen Anne's Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Factory worker		12b. KIND OF BUSINESS OR INDUSTRY Food industry	
13a. STATE Maryland		13b. COUNTY Kent	
13c. CITY OR TOWN Rock Hall		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS / ZIP CODE Rural rt. 21661		14. FATHER'S NAME FIRST MIDDLE LAST Christopher Columbus Kelley	
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie McClain		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
16b. SOCIAL SECURITY NO. 220-26-1188		17. INFORMANT ADDRESS MD 21661 Audrey Coleman, Rt. 2 Box C11, Rock Hall	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerosis - Debridement</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>[Signature]</u>		22c. DATE SIGNED 2/13/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>[Signature]</u>		22e. ADDRESS DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 02/16/85	
23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Rock Hall Kent MD	
24. FUNERAL DIRECTOR NAME Tom Helfenbain Funeral Homes, Chester, MD 21619		25a. DATE REC'D. BY REGISTRAR MAR 1 1985	
25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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WILEY

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1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 4 4 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Hope H. XXXX Jones			2a. DATE OF DEATH February 24, 1985			2b. HOUR 6:29 PM			
3 SEX Female		4 RACE White		5. DATE OF BIRTH October 15, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 89		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD.			
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Kent and Queen Anne's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md. Kent Still Pond		13b. CITY OR TOWN Still Pond		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE P.O. Box # 21667			
14. FATHER'S NAME FIRST MIDDLE LAST Willis K. Hackett				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Dalton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 219 46 4989		17. INFORMANT ADDRESS Hope J. Lynch Towson, Md.					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Sudden Cardiac Death DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour Many years.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from January 23, 1985, to February 24, 1985, that (I) (we) last saw the deceased alive on February 24, 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Charles P. Adams MD						DEGREE M.D.		22c. DATE SIGNED February 25, 1985	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. P. Adams M.D.						22e. ADDRESS Chestertown, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 2/27/85		23c. NAME OF CEMETERY OR CREMATORY Still Pond, Md.		23d. LOCATION CITY OR TOWN COUNTY STATE Still Pond, Md.		
24. FUNERAL DIRECTOR NAME J. Willis Wells						ADDRESS Chestertown, Md.		25a. DATE REC'D. BY REGISTRAR MAR 06 1985	
						25b. REGISTRAR'S SIGNATURE Julia [Signature]			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 4 4 6

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Pauline Elizabeth Jones			2a. DATE OF DEATH MONTH DAY YEAR February 7 85			2b. HOUR P 12:45	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 29 1918		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.	
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent and Queen Anne's Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
13a. STATE Md.		13b. COUNTY Queen Annes Chestert		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Harry Wallace		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Dixon		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO			
17. SOCIAL SECURITY NO. 219-16-3101		18. INFORMANT Sue McMullen Chestertown, Md 21620					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Patrick Maloney				DEGREE M.D.		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Patrick Maloney				22e. ADDRESS Chestertown, Md. Kent & Queen Annes Hospital			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 11, 85		23c. NAME OF CEMETERY OR CREMATORY Galena Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Galena Kent Md.	
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24. FUNERAL DIRECTOR NAME Follows Funeral Home Mullington		25. DATE RECEIVED BY REGISTRAR FEB 11 1985		26. REGISTRAR'S SIGNATURE John Davidson-Randall	
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RECEIVED
JUL 11 1964
U.S. DEPT. OF JUSTICE

DO NOT
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DO NOT
REPLY

DO NOT
REPLY



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

85 05447

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) MARGARET GRIFFITH. McCauley			2a. DATE OF DEATH MONTH DAY YEAR 2-5-85			2b. HOUR 12:30 PM				
3. SEX F.		4. RACE W.		5. DATE OF BIRTH MONTH DAY YEAR 6 30 '88		6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH KENT MD.				
10. CITY OR TOWN OF DEATH CHESTERTOWN		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MAGNOLIA HALL INC.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOMEMAKER		
13a. STATE MD			13b. COUNTY KENT		13c. CITY OR TOWN GEORGETOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS GALENA MD. 21635	
14. FATHER'S NAME FIRST MIDDLE LAST ANDREW WASHINGTON WOODALL			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ALICE IRVING GRIFFITH							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-70-3148A		17. INFORMANT 102 SUNRISE AVE RIDGELEY MD MRS. ORRELL SAULSBURY III 21660.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCVD with Cardiomegaly DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Arthritis									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 2-5-85 , to 2-5 , 19 85 , that (I) (we) last saw the deceased alive on 2-5-1985 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Robert W. Farr</i>						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-8-85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert W. Farr, M.D.						22e. ADDRESS Chestertown, Maryland 21620				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 2/9/85		23c. NAME OF CEMETERY OR CREMATORY GALENA CEMETERY		23d. LOCATION CITY OR TOWN COUNTY STATE GALENA KENT MD.			
24. FUNERAL DIRECTOR NAME Marvin V. Waller						CITY OR TOWN CHESTERTOWN, MD.		25a. DATE REC'D. BY REGISTRAR FEB 14 1985		
						25b. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>				

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 4 4 8

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Clayton NMN Morris Jr.			2a. DATE OF DEATH MONTH DAY YEAR 2-18-85		2b. HOUR 6:05PM			
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 3-10-1901		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS. MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN) MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.		
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's Hospital Inc.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABOR		12b. KIND OF BUSINESS OR INDUSTRY VARIOUS		
13a. STATE MD			13b. COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Spencer Morris			15. MOTHER'S MAIDEN NAME FIRST MIDDLE Susie			13e. STREET ADDRESS / ZIP CODE Queen St. 21620		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1-10-11-23		17. INFORMANT ADDRESS Mrs. Haze Deaton Centerville, MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ca of lung with liver metastasis</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE K.K. Ullman				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KIN KUE WUN				22e. ADDRESS Chestertown, MD - 21620				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 2-22-1985		23c. NAME OF CEMETERY OR CREMATORY MD. E. S. VET. CEM.		23d. COUNTY BALTIMORE		
24. FUNERAL DIRECTOR NAME James W. Wally				ADDRESS Chestertown, MD		25a. DATE REC'D. BY REGISTRAR FEB 26 1985		
				25b. REGISTRAR'S SIGNATURE Lila Davidson-Randall				

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



NOTICE

TO THE



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			REG. NO.			8 5 0 5 4 4 9			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Rebecca Mae Nasheim					2a. DATE OF DEATH MONTH DAY YEAR 2- 2- 85			2b. HOUR 10:03P_M			
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Oct. 29, 1892		6. AGE (IN YEARS LAST BIRTHDAY) 92		IF UNDER 1 YEAR MONTHS DAYS YRS		IF UNDER 24 HRS HOURS MIN. 10:03P_M	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kent Co. Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.					
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's Hospital, Inc.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY			
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY Kent 13c. CITY OR TOWN Chestertown					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 532 West High 21620				
14. FATHER'S NAME FIRST MIDDLE LAST G. Thomas Willis					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Dill						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no		16b. SOCIAL SECURITY NO. 329 22 6082		17. INFORMANT ADDRESS Maxwell Willis Galena, Md. 21635							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease with</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } (b) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Vomiting, Diarrhea, and Dehydration											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 2-2, 19 85 , to 2-2, 19 85 , that (I) (we) last saw the deceased alive on 2-2, 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE 					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2-4-85				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert W. Farr, M.D.					22e. ADDRESS Chestertown, MD 21620						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/6/85		23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Chestertown, Md.					
24. FUNERAL DIRECTOR NAME ADDRESS J. W. Wells Chestertown, Md.					25a. DATE REC'D. BY REGISTRAR FEB 7 1985		25b. REGISTRAR'S SIGNATURE 				

10% COTTON FIBRE

MADE IN
ENGLAND



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or blank, it shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 5 0 5 4 5 0			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST William Clayton Phillips				2a. DATE OF DEATH MONTH DAY YEAR 2- 28- 85		2b. HOUR 9:30P _M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 13, 1903		6. AGE (IN YEARS LAST BIRTHDAY) 82 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD	
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's Hospital Inc.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auto Repair & Upholsterer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Kent		13c. CITY OR TOWN Millington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Franklin Phillips		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Bedwell		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No			
16b. SOCIAL SECURITY NO. 220-32-0801		17. INFORMANT ADDRESS Richard Phillips, P. O. Box 213, Sudlersville, MD 21668					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septic Shock</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Broncho pneumonia, Embolism</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>U.G.I. Bleed - Massive</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>[Signature]</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 2/28/85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 03/05/85		23c. NAME OF CEMETERY OR CREMATORY Sudlersville Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Sudlersville KENT MD	
24. FUNERAL DIRECTOR NAME Tom Helfenbein Funeral Home, Church Hill, MD				25a. DATE REC'D. BY REGISTRAR MAR 6 1985		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

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1000



On the 10th day of the month of January 1900, the following was observed:

BP

DHMH-16 30M 2/80
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the registrar. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified as soon as possible.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 5 0 5 4 5 1			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		2b. HOUR	
FIRST MIDDLE LAST ETHEL EVERETT PRICE				MONTH DAY YEAR FEB. 5, 1985		7:00 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE	
FEMALE		CAUC.		MONTH DAY YEAR APRIL 9, 1892		YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
CAROLINE CO, MD		USA				KENT MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
MILLINGTON		#1 SPEER ROAD		HOMEMAKER		HOME	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. INSIDE CITY LIMITS?		13b. STREET ADDRESS	
13a. STATE 13b. COUNTY 13c. CITY OR TOWN MARYLAND KENT MILLINGTON				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		BOX 174 CYPRESS ST. 21651	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST EMORY EVERETT				FIRST MIDDLE LAST ANNIE MNM EMORY			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
NO		218-20-4191		PAUL C. PRICE son SPEER RD. MILLINGTON MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>ASCD & chronic atherosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>MI</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
MICHAEL BEY M.D.				UNICORN MEDICAL CENTER, MILLINGTON, MD 21651			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
BURIAL		2/9/85		HICKORY GROVE CEM.		PORT PENN, NEW CASTLE, DEL	
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
NAME ADDRESS FELLOWS F.H. BOX 270 MILLINGTON, MD 21651				FEB 11 1985		<i>John David Ruppel</i>	

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 4 5 2

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Ethel NMN Rollison		2-10-85		4:30 P.M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YEAR	
female	White	Mar 27, 1890	1/ 94	MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	USA		Kent MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Chestertown	Kent & Queen Anne's Hospital Inc.	Inspector Drug Firm	21620		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS / ZIP CODE	
Md.	Kent	Chestertown	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	21620	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Cornelius Rollison		Clara Clendaniels			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT		ADDRESS	
no	163 09 8410	Gertrude Rollison		Rock Hall, Md. 21661	
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis with severe upper respiratory infection DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (i) Severe hypoxemia , Severe respiratory acidosis, Severe Kyphoscoliosis					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1; OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 2-10-85 to 2-9-85, to 2-10-85, 19-85, that (I) (we) last saw the deceased alive on 2-10-85, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<i>Robert W. Farr</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		2-11-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Robert W. Farr, M.D.		Chestertown, Maryland 21620			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial	2/13/85	Chester Rural Cem.		Chester, Pa.	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
<i>William Wells</i>		FEB 15 1985		<i>Julia Davidson Rondella</i>	

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

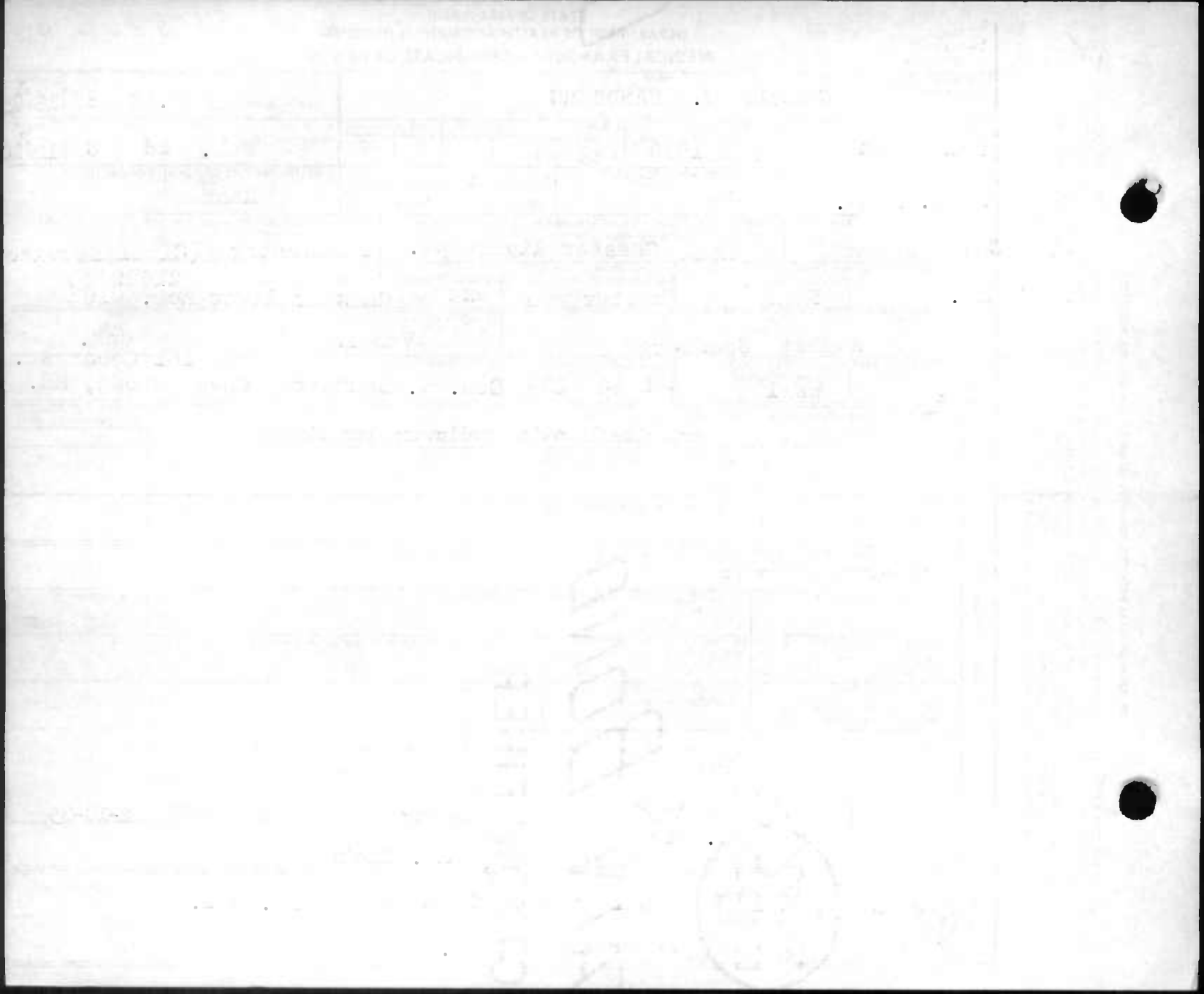
DHMH - 17
(VR A15 ME (5))
20M 4/82

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) GEORGE W. SANDBERG			2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> MONTH DAY YEAR Feb. 18 1985			2b. HOUR 12:05 A			
3. SEX Male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 6/22/1896	6. AGE (IN YEARS) LAST BIRTHDAY 88 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Feb. 18 1985			2d. HOUR 12:20 A
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Minn. Minn.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent			
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) At Home Chester River Apt.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Postmaster (Civil Service)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21620 Chester River Apt. #102	
14. FATHER'S NAME FIRST MIDDLE LAST August Sandberg				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Vendla unk.				ADDRESS 101 Cedar St. Chestertown, Md.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 1 470 44 9086		17. INFORMANT Geo. W. Sandberg			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a). Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (b). DUE TO, OR AS A CONSEQUENCE OF (c).									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Pulmonary emphysema									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE Robert W. Farr			TITLE (SPECIFY) Deputy			DATE SIGNED 2-18-85			
EXAMINER'S NAME (TYPE OR PRINT) Robert W. Farr			ADDRESS Kent County Chestertown, Md. 21620						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 2/18/85		23c. NAME OF CEMETERY OR CREMATORY Silverbrook Crematory Wilm. Del.			23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME Wells Wells			ADDRESS Chestertown, Md.			25a. DATE REC'D. BY REGISTRAR 2-25-85		25b. REGISTRAR'S SIGNATURE John Davidson-Randall	



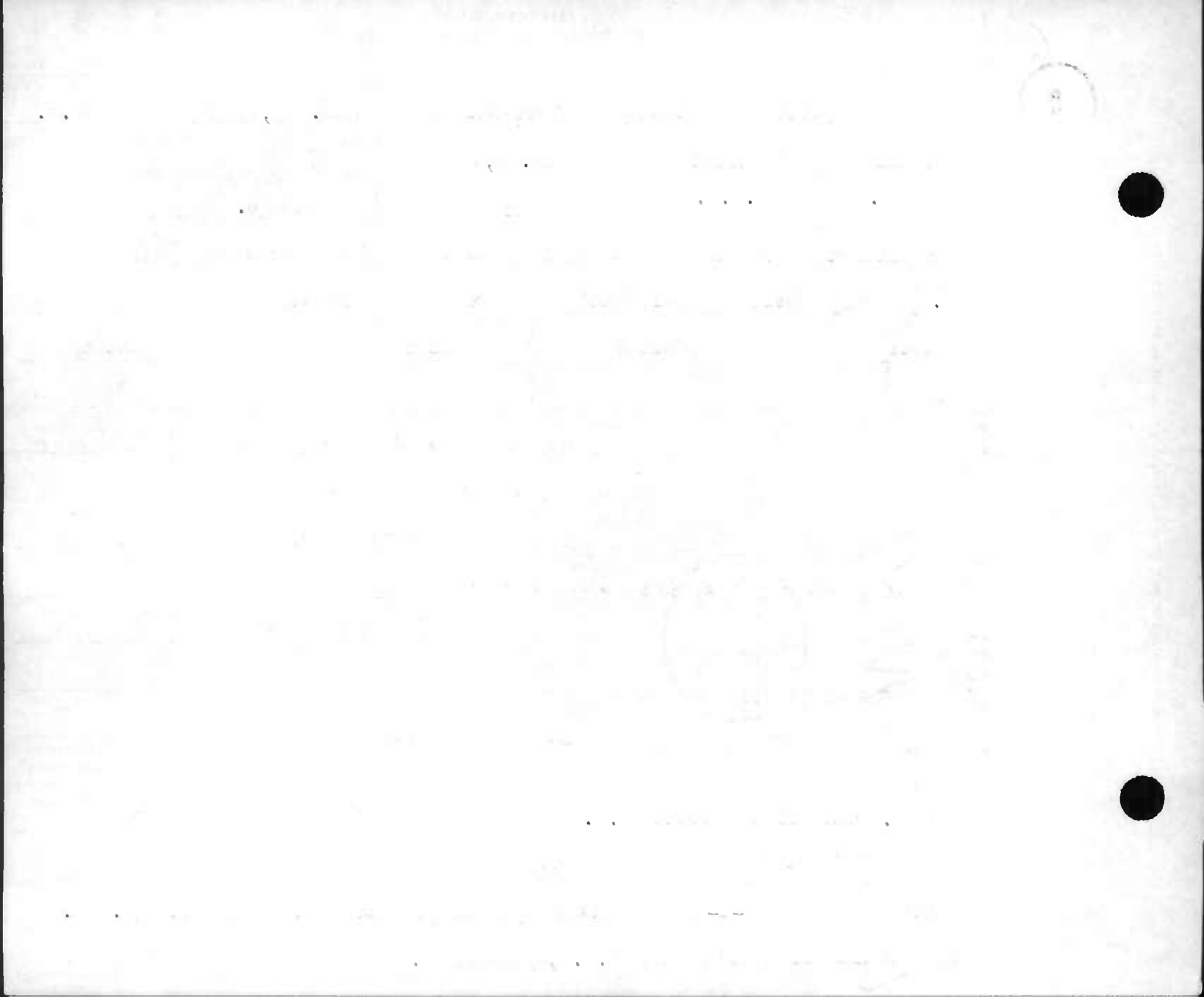
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
FOR 1 - STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Edith Gladys Thompson</i>						2a. DATE OF DEATH MONTH DAY YEAR <i>Feb. 27, 1985</i>		2b. HOUR <i>3 P.M.</i>	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Feb. 6, 1900</i>		6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS <i>85</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Kent Co.</i>			
10. CITY OR TOWN OF DEATH <i>Chestertown</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Magnolia Hall Nursing Home</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Seamstress and Cook</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md.</i>		13b. COUNTY <i>Kent</i>		13c. CITY OR TOWN <i>Rock Hall</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>rural 21661</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>John Warner</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Marie Ashley</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic Cardiovascular</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Dissection</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4 hours</i> <i>several years</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Marked Cerebrovascular Disease</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>Aug 2/84</i> , 19 <i>84</i> , to <i>2/27</i> , 19 <i>85</i> , that (I) (we) lost saw the deceased alive on <i>2/27</i> , 19 <i>85</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Dr. Gottfried Boumann M.D.</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>3/1/85</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Gottfried Boumann</i>				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (a) <i>Burial</i>		23b. DATE <i>3-2-85</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Wesley Chapel Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Rock Hall Kent Co. Md.</i>			
24. FUNERAL DIRECTOR NAME ADDRESS <i>Tom Helfenbein Funeral Home P.A., Chester Md.</i>				25a. DATE REC'D. BY REGISTRAR <i>MAR 6 1985</i>		25b. REGISTRAR'S SIGNATURE <i>John Davidson</i>			



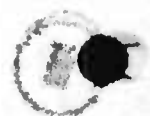
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH-17
(FRA 15 ME (5))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE KNOWN OF DEATH		2b. DATE KNOWN OF DEATH		2c. DATE KNOWN OF DEATH		2d. DATE KNOWN OF DEATH	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE KNOWN OF DEATH	
Charles Melvin		URIE						2b. DATE KNOWN OF DEATH	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 1 YR.	
Male		White		May 3, 1914		70 YRS.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH	
Balto. Md.		USA		WIDOWED		DIVORCED		Kent	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Chestertown		Kent & Queen Anne's Hospital		Mason (Brick Layer)					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		Queen Anne		Barclay		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		P.O. Bx # 56 21607	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		17. INFORMANT	
Charles Robert Urie		Julia W. Joiner		no		216 10 3908		Bertha C. Urie Barclay, Md. 21607	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				Arteriosclerotic Cardiovascular Disease with		Cardiac Arrest			
				(b)		DUE TO, OR AS A CONSEQUENCE OF			
				(c)					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
		HOUR A.M. MONTH DAY YEAR							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY	
				STREET				STATE	
22a. I certify that I took charge of the remains described above, held an		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input type="checkbox"/>		and in my opinion	
death resulted from:		Natural causes <input checked="" type="checkbox"/>		Accident <input type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>	
								Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE		SIGNED		2-25-85	
Robert W. Farr, M.D.		Deputy		MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		Chestertown, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		COUNTY	
Burial		2/27/85		Wesley Chapel Cem.		Rock Hall, Md.		STATE	
24. FUNERAL DIRECTOR		NAME		ADDRESS		25. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
J. Wells Wells		Chestertown, Md.				MAR 06 1985		J. Wells Wells	



OFFICIAL

2012-2013

THE UNIVERSITY OF THE STATE OF NEW YORK
OFFICE OF THE STATE EDUCATION EXAMINER
ALBANY, NEW YORK

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 4 5 6

1 - FOR
STATE
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Arthur Washington Warren			2a. DATE OF DEATH MONTH DAY YEAR February 22, 85			2b. HOUR A. 4:30 M	
3 SEX Male		4 RACE Black		5 DATE OF BIRTH MONTH DAY YEAR Oct. 25, 1907		6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Kent MD	
10 CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Magnolia Hall Nursing Home		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labor		12b. KIND OF BUSINESS OR INDUSTRY Various	
13a STATE Maryland		13b COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. STREET ADDRESS R.F.D. #3 21620	
14 FATHER'S NAME FIRST MIDDLE LAST George Warren		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marcie Smith		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			
16b SOCIAL SECURITY NO. YES		17 INFORMANT ADDRESS R.F.D. #3 Mrs. Myrtle Warren Chestertown, Md.					

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):
PART I. DEATH WAS CAUSED BY

IMMEDIATE CAUSE (a) **Respiratory Infection**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

Sepsis, Chronic urinary tract infection, Staphylococcus aureus

19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		19c. AUTOPTSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from 2-18 , 19 83 , to 2-22 , 19 85 , that (I) (we) last saw the deceased alive on 2-22 , 19 85 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b SIGNATURE Robert W. Farr M. D.				DEGREE		22c. DATE SIGNED 2-23-85	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert W. Farr M. D.				22e. ADDRESS Chestertown, Maryland 21620			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Feb. 26, 1985		23c. NAME OF CEMETERY OR CREMATORY Jones Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Chestertown, Kent, Md.	
24 FUNERAL DIRECTOR NAME Remett W. D.				ADDRESS Chestertown, Md.		25a. DATE REC'D. BY REGISTRAR FEB 26 1985	
25b. REGISTRAR SIGNATURE Robert W. Farr							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked off item 18, any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 60M 7/84
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8505457

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		2b. HOUR	
Evelyn Catherine Wiedenmayer		2-9-85		5:13P M.	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR	
Female	White	MONTH DAY YEAR	78 YRS.	IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
New Jersey	U.S.A.		Kent MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY		
Chestertown	Kent & Queen Anne's Hospital Inc.	Dietician	Teaching		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS / ZIP CODE	
Md.	Kent	Worton		Box 51 21678	
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			
Joseph F.	Kelly Louise	16b. SOCIAL SECURITY NO. 142-07-7179			
17. INFORMANT		ADDRESS RD. 1 Kennedyville			
George W. Wiedenmayer					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Myocardial Infarction					3 weeks
DUE TO, OR AS A CONSEQUENCE OF					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					
DUE TO, OR AS A CONSEQUENCE OF					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 2/9 1985 to 2/9 1985, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED		
C. GOTTFRIED BAUMANN	MD		2/11/85		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS				
C. GOTTFRIED BAUMANN	MEDICAL Bldg Chestertown MD 21620				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	Feb. 13, 1985	Galena Cemetery	Galena	Kent	Md.
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Fellows Funeral Home		FEB 1 9 1985		Julia Davidson-Rondella	

20% COTTON FIBER

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 5 0 5 4 5 8

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Edna Kelly Wroth			2a. DATE OF DEATH MONTH DAY YEAR February 21, 1985		2b. HOUR P M 2:30 P			
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR May 2, 1885		6. AGE (IN YEARS LAST BIRTHDAY) 99 yrs. YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kent Co. Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent County MD.		
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent and Queen Anne's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk Storne		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Kent		13c. CITY OR TOWN Still Pond		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST William Frisby Wroth			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Florence Kelly					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218 12 1254		17. INFORMANT ADDRESS I.U. Church Records Lynch, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia LLC</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>12</u> 19 <u>78</u> to <u>2/21</u> 19 <u>85</u> , that (I) (we) last saw the deceased alive on <u>2/21</u> 19 <u>85</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>[Signature]</u>				DEGREE		22c. DATE SIGNED <u>2/21/85</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. Gottfried Baumann, M.D.				22e. ADDRESS Chestertown, Maryland 21620				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2/25/85		23c. NAME OF CEMETERY OR CREMATORY Still Pond Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Still Pond, Md.		
24. FUNERAL DIRECTOR NAME <u>Wells</u>				ADDRESS Chestertown, Md.		25a. DATE REC'D. BY REGISTRAR FEB 28 1985		
				25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please detach for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

